SENATE BILL NO. 458

INTRODUCED BY G. BARKUS

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR NONDUPLICATION OF BENEFITS UNDER VARIOUS FORMS OF HEALTH INSURANCE AND GOVERNMENTAL ENTITY HEALTH BENEFIT PLANS; PROVIDING FOR REIMBURSEMENT OF HEALTH INSURANCE PAYMENTS BY HEALTH CARE PROVIDERS WHEN THE PAYMENTS ARE ALSO PAID BY ANOTHER INSURER OR HEALTH CARE PROVIDER; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. No duplication of benefits -- reimbursement.** (1) A health insurance issuer that provides individual, group, blanket, or other health insurance coverage is not responsible under that health insurance coverage to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which:

(a) payment has been made to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage; or

(b) medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition.

(2) A health insurance issuer may request and is entitled to obtain from an insured, another insurer, or other person the following information regarding the existence and details of any payments made by or for which medical payments coverage is available from another insurer with respect to an injury or medical condition that is subject to the provisions of subsection (1):

(a) whether the other insurer has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy with respect to the injury or medical condition subject to the provisions of subsection (1);

(c) the particular services, supplies, medications, or other items for which the other insurer has paid;

(d) the identity of any health care provider or other persons paid by the other insurer for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the health insurance issuer to determine coverage under

the terms of the health insurance issuer's policy, certificate, membership contract, or evidence of coverage.

(3) A health insurance issuer may demand and receive reimbursement or a credit from a health care provider for the health insurance issuer's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition subject to the provisions of subsection (1) sustained by an insured that were also paid for by any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage.

(4) A health insurance issuer's exclusion of coverage or payment or receipt of reimbursement or credit from a health care provider pursuant to this section may not be considered subrogation and is not subject to the application of:

(a) 33-22-1601 and 33-22-1602; or

(b) any condition or prerequisite that the insured be fully compensated or made whole for the insured's injury or medical condition.

(5) A health insurance issuer may include in any policy, certificate, membership contract, or evidence of coverage for health insurance coverage a provision substantially as follows: "No Duplication of Benefits: The insurer is not responsible under this contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which payment has been made to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage or for which medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition."

(6) A health insurance issuer may include in any policy, certificate, membership contract, or evidence of coverage other limitations, exclusions, or reductions of coverage that are designed to prevent duplicate payments for services, supplies, medications, or other items that have been paid or for which coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage.

(7) (a) A health insurance issuer shall credit the amount of any payments described in subsection (1) toward satisfaction of the insured's deductible, coinsurance, or copayments applicable under the insured's policy, certificate, membership contract, or evidence of coverage for purposes of a claim submitted to the health insurance issuer that is incurred by the insured during the same benefit year applicable to the deductible, coinsurance, or copayments.

(b) Subsection (7)(a) does not require a health insurance issuer to:

(i) credit payments described in subsection (7)(a) for a claim if the claim would not be covered or paid under the terms of the insured's policy, certificate, membership contract, or evidence of coverage, even without the application of any deductible, coinsurance, or copayments; or

(ii) pay a health care provider an amount that, taking into account another insurer's payment to the health care provider, would result in the health care provider receiving total payments in excess of the amount allowable under the terms of the insured's policy, certificate, membership contract, or evidence of coverage.

NEW SECTION. **Section 2. No duplication of benefits -- reimbursement.** (1) The association and any association plan are not responsible to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which:

(a) payment has been made to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage; or

(b) medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition.

(2) The association or its lead carrier on behalf of the association may request and is entitled to obtain from an insured, another insurer, or other person the following information regarding the existence and details of any payments made by or for which medical payments coverage is available from another insurer with respect to an injury or medical condition that is subject to the provisions of subsection (1):

(a) whether another insurer has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy with respect to the injury or medical condition subject to the provisions of subsection (1);

(c) the particular services, supplies, medications, or other items for which the other insurer has paid;

(d) the identity of any health care provider or other persons paid by the other insurer for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the association or its lead carrier to determine coverage under the association plan.

(3) The association or its lead carrier on behalf of the association may demand and receive reimbursement or a credit from a health care provider for the association's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition subject to the provisions of

subsection (1) sustained by an insured that were also paid for by any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage.

(4) The association's exclusion of coverage or payment or receipt of reimbursement or credit from a health care provider pursuant to this section may not be considered subrogation and is not subject to the application of:

(a) 33-22-1601 and 33-22-1602; or

(b) any condition or prerequisite that the insured be fully compensated or made whole for the insured's injury or medical condition.

(5) The association or its lead carrier on behalf of the association may include in any association plan contract a provision substantially as follows: "No Duplication of Benefits: The association is not responsible under this contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which payment has been made to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage or for which medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition."

(6) The association or its lead carrier on behalf of the association may include in any association plan contract other limitations, exclusions, or reductions of coverage that are designed to prevent duplicate payments for services, supplies, medications, or other items that have been paid or for which coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage.

NEW SECTION. **Section 3. No duplication of benefits -- reimbursement.** (1) A governmental entity or a health insurance issuer that issues a health plan or a health insurance contract under this part is not responsible under the plan or contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which:

(a) payment has been made to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage; or

(b) medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition.

(2) A governmental entity or a health insurance issuer that issues a health plan or a health insurance contract under this part may request and is entitled to obtain from an insured, another insurer, or other person the following information regarding the existence and details of any payments made by or for which medical payments coverage is available from another insurer with respect to an injury or medical condition that is subject to the provisions of subsection (1):

(a) whether another insurer has made any payments described in subsection (1);

(b) the existence and limits of any medical payments coverage available under any insurance policy with respect to the injury or medical condition subject to the provisions of subsection (1);

(c) the particular services, supplies, medications or other items for which the other insurer has paid;

(d) the identity of any health care provider or other persons paid by the other insurer for each particular service, supply, medication, or other item; and

(e) other information reasonably necessary for the governmental agency or health insurance issuer to determine coverage under the terms of the governmental agency's or health insurance issuer's policy, certificate, membership contract, or evidence of coverage.

(3) A governmental entity or health insurance issuer that issues a health plan or a health insurance contract under this part may demand and receive reimbursement or a credit from a health care provider for the health insurance issuer's payment for any services, supplies, medications, or other items provided to treat any injury or medical condition subject to the provisions of subsection (1) sustained by an insured that were also paid for by any first-party medical payments coverage,third-party medical payments coverage, or third-party liability coverage.

(4) A governmental entity's or health insurance issuer's exclusion of coverage or payment or receipt of reimbursement or credit from a health care provider pursuant to this section may not be considered subrogation and is not subject to the application of:

(a) 2-18-901 and 2-18-902; or

(b) any condition or prerequisite that the insured be fully compensated or made whole for the insured's injury or medical condition.

(5) A governmental entity or health insurance issuer may include in any health plan or health insurance contract issued under this part a provision substantially as follows: "No Duplication of Benefits: The plan or insurer is not responsible under this contract to cover or pay for any services, supplies, medications, or other items provided to treat any injury or medical condition sustained by an insured for which payment has been made

to a health care provider, insured, or other person under first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage or for which medical payments coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage with respect to the injury or medical condition."

(6) A governmental entity or health insurance issuer may include in any health plan or a health insurance contract issued under this part other limitations, exclusions, or reductions of coverage that are designed to prevent duplicate payments for services, supplies, medications, or other items that have been paid or for which coverage is available under any first-party medical payments coverage, third-party medical payments coverage, or third-party liability coverage.

NEW SECTION. **Section 4. Codification instruction.** (1) [Section 1] is intended to be codified as an integral part of Title 33, chapter 22, part 1, and the provisions of Title 33, chapter 22, part 1, apply to [section 1].

(2) [Section 2] is intended to be codified as an integral part of Title 33, chapter 22, part 15, and the provisions of Title 33, chapter 22, part 15, apply to [section 2].

(3) [Section 3] is intended to be codified as an integral part of Title 2, chapter 18, part 7, and Title 2, chapter 18, part 8, and the provisions of Title 2, chapter 18, part 7, and Title 2, chapter 18, part 8, apply to [section 3].

NEW SECTION. **Section 5. Effective date.** [This act] is effective on passage and approval.

NEW SECTION. **Section 6. Applicability.** [This act] applies to claims submitted to a health insurance issuer, the comprehensive health association, and a governmental entity or health insurance issuer under Title 2, chapter 18, parts 7 and 8, and to reimbursement or credit demanded or received by a health insurance issuer, the comprehensive health association, and a governmental entity or health insurance issuer under Title 2, chapter 18, parts 7 and 8, from a health care provider or an insured on or after [the effective date of this act].

- END -